

**Table 2**  
Pathogen.

Pathogen	Number of Infections
<b>Bacterial (Total)</b>	<b>10 (33.3%)</b>
Klebsiella	6
Enterococcus	1
E.Coli	2
C.Difficile	1
<b>Viral (Total)</b>	<b>11 (36.67%)</b>
CMV	7
Varicella Zoster	4
<b>Fungal (Total)</b>	<b>4 (13.33%)</b>
Candida	2
Aspergillus	2
<b>Unknown</b>	<b>5 (16.67%)</b>

**Table 3**  
Site.

BACTERIAL	Number of infections
Blood Stream	5
Surgical Site	1
Respiratory Tract	1
Genito-Urinary Tract	2
Intra- Abdominal	1
<b>VIRAL</b>	
Blood Stream	7
Skin and Soft Tissue	4
<b>FUNGAL</b>	
Blood Stream	2
Respiratory Tract	2
<b>UNKNOWN</b>	
Genito-Urinary Tract	1
Intra-Abdominal	1
Respiratory Tract	2
Skin and Soft Tissue	1

infections post liver transplant in the indian scenario and this data can be used to plan appropriate preventive strategies

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#### A case of liver transplant in leptospirosis induced acute on chronic liver failure

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**Background:** Solid organ transplants are increasing in India. Guidelines on liver transplant postoperative infections are limited. We report a child with leptospirosis who underwent a liver transplant.

**Methods & Materials:** We review a case of a 12 year old male with Wilsons disease who presented with febrile illness and acute on chronic liver failure who was admitted at a tertiary care center and subsequently underwent a liver transplant.

**Results:** A 12 year old boy with Wilsons disease presented with a febrile illness and acute on chronic liver disease. He was

evaluated for the cause of acute on chronic liver failure and found to have leptospirosis based on identifying spirochetes in the blood and urine. He was treated initially with cefaperazone-sulbactam and subsequently with doxycycline. His pretransplant period was complicated by Acinetobacter pneumonia and bacteremia. After optimizing the clinical condition he underwent a living donor liver transplant. He improved post-transplant for 2 weeks. Subsequently he developed CMV viremia, treated with ganciclovir. He developed multiple skin necrotic areas which was concerning for septic emboli. He had unexplained leukocytosis. Computerized tomography revealed cavitory lesions in the left upper lobe and right lower lobe, consolidation of left lower lobe, kidney infarction and mucosal thickening of the maxillary and sphenoid sinus. Due to the high risk of biopsy, bronchoscopy was done and bronchoalveolar fluid (BAL) was analyzed. Fungal stain of the BAL was positive and culture was suggestive of Mucor in both the left upper and lower lobes. He was started on Amphotericin B deoxycholate. Subsequently he developed seizures and had features of brain death, presumed due to spread of the mucormycosis.

**Conclusion:** There is no report of liver transplant post leptospirosis. This child underwent a liver transplant following leptospirosis in the background of Wilsons disease. He survived for a few weeks post-transplant but unfortunately died due to mucormycosis, a disease more common in a country like India. Here we were able to diagnose the mucormycosis ante-mortem with BAL and did not require tissue. Strong clinical suspicion, better diagnostics and early initiation of therapy is warranted. Unfortunately due to extensive fungal disease, we could not salvage him.

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#### An unusual presentation of invasive aspergillosis - Diagnostic and management dilemmas

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**Background:** Invasive Aspergillosis is a fungal infection occurring with increased incidence in patients who are receiving chemotherapy, immunosuppressive therapy or long term corticosteroid therapy. Among these, it more commonly afflicts patients with pre-existing respiratory compromise such as COPD or bronchial asthma. Typically it presents with fever, cough, dyspnoea, pleuritic chest pain and occasionally with haemoptysis.

**Methods & Materials:** Case Report:

A 60 year old male patient presented to the emergency department with complaints of an intermittent, high grade fever for the

